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It might be supposed that the most enlightened areas in the country would be the freest from these diseases and that the places where no enlightenment had been undertaken would be hotbeds of disease. He had examined in this respect sixteen counties which had not undertaken any propaganda for ten years ; they comprised about one-third of the country. Actually the number of service infections in those areas had been lower than the average for the country. He was not saying, of course, that the lack of enlightenment had reduced the amount of venereal disease, but there the facts were. He had to thank all those who had contributed to a useful discussion.

III

THE NEED FOR FURTHER POWERS TO DEAL WITH SOURCES OF INFECTION, CONTACTS AND DEFAULTERS *

By MAJOR S. M. LAIRD, R.A.M.C.

FOR centuries venereal diseases have been recognised as contagious and the group name clearly defines the method whereby infection spreads. For some generations gonorrhœa and syphilis have been differentiated on clinical grounds and for decades the causative organisms have been known and laboratory tests have aided accurate diagnosis. In the past thirty years two potent drugs capable of curing the individual case of syphilis have been introduced and in the last five years we have witnessed a revolution in the treatment of gonococcal infection by yet another development of chemotherapy. The control of infection in this country, however, has not shared in the progress achieved in the other aspects of V.D. and it is difficult to understand or condone the complacency with which this unsatisfactory position is tolerated. This problem of control has exercised the minds of a Royal Commission, several Committees of Inquiry and many social workers both within and outside the ranks of the medical profession. All these have so far failed to dislodge the obstructions which still hold up progress in the control of these common infectious diseases. I hope that this address will contribute to the weathering and ultimate removal of these stumbling blocks. The views to be expressed are strictly personal ones and their presentation is intended to provoke a full discussion.

Gonorrhœa and syphilis are infectious diseases which recognise no national boundaries. Infected persons may remain contagious for long periods and the national reservoir of infection is constantly re-invigorated with imported spirochætes and gonococci. The control of these diseases is, therefore, difficult and their complete eradication from Britain probably impossible. These difficulties are not peculiar to this country and I think that we have not faced the challenge so realistically or successfully as certain of the Scandinavian countries and, in particular, Denmark and Sweden. The ostrich-like attitude

* An address delivered to the Medical Society for the Study of Venereal Diseases on April 25th, 1942.

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to V.D. hitherto adopted in this country must be replaced by frank discussion of the problem in medico-political circles, the creation by vigorous educational methods of a public demand for action and the extension to V.D. of the mechanism of control so successfully applied in the past to other infectious diseases.

The Public Health (Venereal Disease) Regulations, 1916 made provision for free treatment and diagnostic facilities, the supply of approved drugs to practitioners and the education of the public in matters relating to V.D. The Venereal Diseases Act, 1917 prohibits the treatment of V.D. by any person other than a registered medical practitioner and forbids the public advertisement of drugs purporting to prevent or cure V.D. The law imposes one handicap only upon a person who suffers from V.D. The Matrimonial Causes Act, 1937 allows the Court, with many qualifications, to grant a decree of nullity if one of the partners to a marriage was at the time of the marriage suffering from V.D. in a communicable form. No other legislation exists and any person is free to have V.D. and to communicate it as much as he chooses. He is not obliged to be treated or to continue with treatment when once commenced. He need disclose no information which might assist in bringing the source of his infection under control and even if he is willing and able to trace his consort, the latter can refuse examination and treatment. There is no notification of cases and no accurate knowledge of the incidence of these diseases. Such is the legal position in Britain at the present day.

The recognition of gonococcal infection in the male is usually straightforward. In the female clinical signs are of little value and diagnosis is dependent on the persevering use of microscopic and cultural examination. The collection of exudate for such examinations demands a careful technique as otherwise many infected cases will escape detection. The recognition of syphilis on clinical grounds is largely dependent on the experience of the examiner but none will be satisfied with clinical diagnosis alone and will employ to the full all available laboratory aids to diagnosis. The index of suspicion in the clinician is all-important as without this the confirmatory investigations will be omitted. The index of suspicion of the medical profession in general is deplorably low and much education will be required before it can reach a satisfactory standard. In the absence of the latter, cases will continue to be missed and the control of infection is dependent on the early recognition of as many cases as possible.

The control of infection requires a knowledge of the causative organism, the method of spread, efficient diagnosis and treatment and the discovery of the source of infection and all other contacts. In relation to gonorrhœa and syphilis our knowledge of the first two is complete; in theory, the third requirement is possible but, in practice, failure may occur from diagnostic delay or from inadequate treatment; and the fourth requirement is infrequently met for a variety of reasons to be discussed later. This analysis indicates, therefore, that the principal saboteurs of the control of venereal disease are the technical imperfections of the medical profession, the defaulting patient and the untraced source of infection and contacts. The elimination of the former might be achieved in time by the insistence on a higher standard of undergraduate training in V.D. as suggested by the Royal Com-

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mission on Venereal Diseases over 25 years ago. With the overcrowding of the present curriculum this solution is unlikely to be accepted but the diagnosis and treatment of V.D. might be restricted to registered medical practitioners who have successfully passed through a standardised postgraduate course of theoretical and practical instruction in this speciality. The way is now open for a fuller consideration of the problems presented by the defaulter, the source of infection and the other contacts.

A patient may default before the completion of treatment or before cure can be pronounced. The latter may imperil his future health; the former, in addition, imperils the public health. Both categories are important: the inadequately treated patient may fall a victim to the later complications of V.D. and thus he and his dependants may become liabilities to the State; the infectious defaulter may infect others of the same and subsequent generation. The defaulter-rate in clinic practice in this country is high. An investigation in various parts of Staffordshire, in which I collaborated, showed that in 1937 50 per cent. of cases of early syphilis and 30 per cent. of gonorrhœa cases defaulted. Sir Kingsley Wood stated that the percentage of clinic patients in England completing treatment and tests of cure was 12.9 per cent. in 1925 and 17.5 per cent. in 1935. This puts the defaulter rate for England in 1935 at 82.5 per cent., which compares most unfavourably with 2.5 per cent., the corresponding defaulter rate for Sweden.

The factors which encourage defaulting are manifold and many are avoidable. The clinic must be adequate in structure and conveniently situated; its hours of attendance must meet the particular requirements of all classes; the staff must be fully trained, skilful, sympathetic and public health conscious. Technique must be beyond reproach and avoidable side-effects of treatment eliminated. There must be time for the full instruction of each new patient in his particular problem, including diagnosis and what it means, treatment and the tracing of his source of infection and all subsequent contacts. The patient suffering from V.D. often needs advice on points other than of a medical nature and with kindly and practical help much progress will be made towards establishing the proper relationship between patient and doctor. This bond will be strengthened by inquiries or remarks later which indicate that the doctor has a personal knowledge of, and interest in, the patient's circumstances. Patients must not be discouraged from presenting their problems as otherwise they will seek advice from their fellow-patients often with most undesirable results. Economic factors must be considered and assistance with travelling expenses may sometimes prevent defaulting. The value of a properly selected and trained almoner has already been demonstrated in certain female clinics in this country and this service should be further developed. With more education of the public it might also be extended to male clinics. I consider that the interview with the almoner should follow, and not precede, the consultation with the medical officer.

In spite of attention to all these points some patients will default. Some of these may be brought back by a suitable postal reminder or by a visit of a social worker. The latter method has recently been reported on favourably from Barnsley, and the results obtained there

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should encourage other local authorities to make similar efforts. This method is unsuitable for male defaulters and some men will not resume treatment unless compelled to do so.

With regard to the source of infection and contacts the position in this country is even more unsatisfactory. The male patient may genuinely be unable to identify his source of infection as the meeting was fortuitous, in which circumstances epidemiological progress is impossible. Sometimes a false sense of chivalry prompts him to plead ignorance of the woman's identity ; other men will advise their consort of the facts but will accept her indignant assertion that " there is nothing wrong with her." A minority of women will visit the clinic and expect a verdict on their first attendance and failure to provide a definite diagnosis after one examination appears to them ample confirmation that, as they thought, they are free from infection. The subsequent contact of a male case is not infrequently his wife who has been exposed to infection during the incubation period of her husband's disease. To bring the wife under treatment jeopardises the marriage ; to fail to do so may mean ill-health for the wife and re-infection of the husband subsequent to the resumption of marital intercourse. The problem is a difficult one for the husband, a delicate one for the clinic officer and involves much unhappiness for the wife but if it is not solved satisfactorily even greater suffering may result. Further education of the population may help to mitigate the practical difficulties but the disillusionment and unhappiness of the innocent partner will always remain. Opinion is divided as to the value of the contact-slip in this field. When used in conjunction with adequate explanation after gaining the patient's confidence, it does bear some fruit ; I found in Stoke-on-Trent that 48 per cent. of all the female V.D. cases at the clinic had reported with a contact-slip. In military practice we give a contact-slip to all men who are able to forward it to their consort and I have had replies from the clinic medical officer in 25 per cent. of cases. It is well recognised that too few women attend at the clinics in this country and this is a measure of the failure of our epidemiological efforts. That these efforts fail under wartime conditions is emphasised by the fact that the number of fresh infections in females attending the clinics in 1940 is less than in previous years in spite of a well-marked increase in the incidence of male infections. The setting up of Ailments of Women Clinics, as recently suggested, may encourage additional female sources of infection and contacts to report for examination.

I submit that the methods employed in this country to control V.D. are not satisfactory. Their trial has now extended over a quarter of a century and other methods should now be considered. That the problem is urgent is indicated by the rapid increase in the incidence of syphilis which has taken place throughout the country in the last eighteen months and with such a large proportion of the relevant age groups under government control the time is opportune for the introduction of legislation to aid the already established methods of control. It is significant that the New York Commission, which, in 1936, studied the anti-venereal measures employed in this and the Scandinavian countries, reported in favour of the compulsory powers in force in the latter countries. An ambitious campaign to control V.D. in the U.S. has since been launched, supported by an intensive

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publicity and educational drive. This campaign is still in its infancy and results are not yet available but its inception a few years before the onset of war was most fortunate for America. Some of the popular educational folders, issued by the U.S. Public Health Service in relation to their campaign against V.D., are excellent. The one entitled "V.D. and National Defense" is an outstanding example.

The American campaign against V.D. cannot yet be assessed. The latter stricture does not apply to the Scandinavian countries where compulsory measures have operated for a quarter of a century. I visited these countries in 1939 and was privileged to study their methods at first hand. My path through Denmark, Sweden and Norway closely followed that of the distinguished Mission appointed in 1937 by the Minister of Health and the Secretary of State for Scotland. Their Report (H.M. Stationery Office, No. 83, 1938), testifies to the thoroughness of their study and is a masterly presentation of the facts. The conclusions, based on these facts, with which the Mission ended their Report, have been criticised both in this country and in America but this does not detract from its value as a source of information concerning V.D. control in the various countries visited.

The present Swedish anti-venereal measures, introduced in 1918, replaced the previous legislation which had as its object the control of V.D. by the State regulation of prostitutes. The campaign for the abolition of the latter developed from the same agency as created the demand for the successful repeal of similar legislation in this country. It is thus interesting to note that the Swedish authorities had the courage and wisdom to replace State regulation of prostitutes with a comprehensive scheme for the control of V.D., while in this country the law-makers fought shy of further legislation. The Swedish law of 1918 applies to syphilis, gonorrhoea and soft sore in an infectious stage and provides that :—

(1) Every person suffering from a V.D. in Sweden must submit to medical treatment and obey any instructions given to him with a view to his own cure or to preventing the infection of others and must continue under treatment until declared non-infectious ;

(2) diagnosis and treatment, including in-patient treatment, is free to all patients ;

(3) a doctor, when examining a patient for the first time, must ascertain where he has already been under treatment by another doctor. If not previously treated, the doctor must send, within 24 hours, a report to the local Inspector of Health stating the diagnosis, sex, age and domicile of the patient, but not the name. The doctor is required at the same time, to try to ascertain from the patient the source of infection. If this information is available it must be reported by the doctor, within 24 hours, to the local Inspector of Health, giving the name and address of the person from whom the disease is alleged to have been contracted ;

(4) knowingly to expose another person to the risk of infection is a punishable offence and annulment of marriage can be obtained by either party if he or she can show that the other party had V.D. in an infectious form at the time of the marriage and that the fact was not disclosed. Each party to a marriage must present a written declaration affirming that he or she is free from V.D. in an infectious form and no person infected with a V.D. may marry without the special permission of the State. A doctor, who has reason to suppose that a person suffering from a V.D. proposes to contract marriage, must immediately report the fact to the local Inspector of Health ;

(5) if a patient ceases attendance for treatment, the doctor, unless he is satisfied

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that the patient is under treatment by another doctor, must report the fact to the Inspector of Health who is then required to serve an order on the patient to submit to treatment in accordance with the provisions of the law. If considered necessary, the patient can be required to enter a public hospital for treatment within a prescribed period. If the order of the Inspector of Health is ignored by the patient, the Health authorities may arrange for a compulsory medical examination of the patient and, if necessary, for his compulsory removal to hospital. In carrying out their duties in this matter the Health authorities are entitled to the assistance of the police, if required ;

(6) a doctor who neglects the provisions of the law regarding instructions to be given to, and the enquiries to be made of, patients suffering from V.D., and the reports to be submitted to the Inspector of Health, is liable to a fine ;

(7) the Health authorities may secure the compulsory medical examination and, when necessary, removal to hospital of (A) a person who has been named as the source of infection by a patient suffering from a V.D., and (B) persons who have been charged with certain sexual offences under the General Penal Code ;

(8) there is a right of appeal to higher authority against the decision of a Health authority in these matters, but the decision already given must be complied with pending the decision on the appeal ;

(9) no person who, by virtue of his official position, has information of any case falling within the scope of the law of 1918, may communicate the same to any other person except in so far as disclosure is required in accordance with his official duties. This provision applies to medical officers in charge of public hospitals and polyclinics as well as to public health officials ; and

(10) the treatment of V.D. by any person who is not properly qualified to practise medicine, is prohibited.

It has been found in Sweden that less than 10 per cent. of the V.D. patients need to be reported for default and, that of these over 75 per cent. are brought back to complete treatment by the use of the powers available. In other words, the proportion of all patients in Sweden who fail to complete the treatment required is about $2\frac{1}{2}$ per cent.

It is of interest to study more fully the mechanism provided by Swedish law for the ascertainment of sources of infection. The doctor is obliged to ascertain from the patient the identity of his source of infection and report it to the Inspector of Health who sends to the reported person a form requiring him to undergo a medical examination and, if he does not report to the Inspector himself for such examination, to furnish a certificate, in prescribed form, from another doctor indicating the result of the examination. If found to be suffering from a V.D. the Inspector directs him to undergo treatment and to provide documentary evidence in confirmation. If considered infectious he may be directed to enter a public hospital for treatment. If a person who has been directed by the Inspector of Health (1) to undergo medical examination, or (2) to report to a doctor for treatment, or (3) to enter a hospital, neglects to comply with such direction, the matter is reported by the Inspector of Health to the Health Authority which issues an order for compulsory examination or treatment. When urgent action is required the Inspector may himself issue the order. This order must immediately be submitted to the Health Authority for approval, but it must be obeyed until countermanded. Appeal may be made to higher authority against the decision of the Health Authority but, here again, the decision already given must be complied with pending the decision on appeal.

The Health Authorities make frequent use of their power to require infected persons to enter hospital. During the ten-year period 1926-1935, in which a total of 137,563 cases of V.D. were notified in Sweden,

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17,480 persons were reported as probable sources of infection (12·7 per cent. of all notifications). Of the persons so reported 14·3 per cent. were untraced and 59·1 per cent. were found to be infected and treated. Probably many of the other sources of infection came under treatment otherwise than by the official machinery of the 1918 law. It has been found in Sweden that the percentage of reported sources of infection is higher in rural areas and small towns than in the larger cities, probably because the country doctor enjoys a more intimate professional relationship with his patients.

The above is an outline of the plan of campaign with which Sweden has tackled her V.D. problem. How does it work in practice and what results has it achieved? With regard to the former the following verbatim quotations from the Report of the British Mission of 1937 speak for themselves :—

“ We gained the impression, from conversations with a number of practitioners engaged in the treatment of V.D., that the Swedish patient is naturally obedient to his doctor and anxious to co-operate in any measures advised for his own health or for the protection of other persons. Little difficulty, for example, is experienced by the doctors in securing the attendance of patients for examination or treatment after the disease has reached a non-infectious stage and the legal obligation to undergo treatment has ceased. We were informed that women who have been discharged from treatment for syphilis will often come voluntarily to a clinic for examination if they subsequently become pregnant, and that patients requiring lumbar punctures will attend for the purpose for years after the expiry of the period of obligatory treatment. The doctors all informed us that they found it of assistance to have the penal provisions of the law behind them: but that, in practice, it is rarely necessary to have recourse to them and that the great majority of patients fully appreciate the importance of continued treatment and follow conscientiously the directions given them ” (p. 52).

Again,

“ We enquired whether there had been any cases of malicious complaint or of blackmail in connection with the arrangements for the ascertainment of sources of infection. There were some instances of malice some years ago, but nowadays it is very rare for any trouble of this sort to be experienced ” (p. 60).

Again,

“ It appears that women patients (other than professional prostitutes) who come under medical treatment for V.D. are more often able and/or willing to supply reliable information regarding sources of infection than are men patients ” and “ Medical officers sometimes find reluctance on the part of a male patient to disclose the name of the woman by whom he was infected arising from a desire to protect her. In such a case the medical officer would probably endeavour to persuade the man to advise the woman to come voluntarily for treatment ” (p. 60).

Again,

“ So far as we could ascertain, persons called on to undergo medical examination seldom raise any serious objection, and appeals are rare.”

With regard to the accuracy of notification the Report states “ the evidence suggests that all but a trivial number of the cases of V.D. coming under the notice of medical practitioners in Sweden are reported,” and, finally, the Mission concluded

“ Our enquiries in Denmark and Sweden, the two countries in which laws specially directed to combating V.D. are in operation, led us to the conclusion that the measures are regarded as beneficial and receive the co-operation of the public. We could find no evidence that the operation of the law has led to concealment of disease to any appreciable extent or imposed undue hardship on the people.”

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The following figures indicate the results obtained in Sweden. It is important to appreciate that although Sweden was a non-belligerent in the war of 1914-18 other conditions were such that she experienced an increase in the incidence of V.D. similar to that of the belligerent countries. The peak was in 1919, in which year the rates per 10,000 of the population for primary and secondary syphilis were: Stockholm 44, rest of Sweden 7.6, all Sweden 10.2. In 1935 these rates had been reduced respectively to 1.8, 0.57 and 0.67. Taking the 1919 rate as 100 per cent. the 1935 rates represent respectively 4.1 per cent., 7.5 per cent. and 6.6 per cent. It will be seen from these percentages, therefore, that Stockholm, in spite of density of population, has achieved a proportionately greater reduction than the rest of the country. The majority of the Swedish cities are seaports and thus the question of imported infections must be considered. In the period 1915-19, 8.8 per cent. of primary and secondary syphilitic infections in males were imported and, in the period 1930-34, this proportion had risen to 31.7 per cent. Applying this correction, roughly, to the total rate per 10,000 of the population in Stockholm the following figures are obtained:—

RATES PER 10,000 OF PRIMARY AND SECONDARY SYPHILIS IN STOCKHOLM, WITH CORRECTION FOR IMPORTED INFECTION					
1919	M.	. 1,156		M.	. 1,051
		1,825	<i>Corrected</i>		1,720
	F.	. 669		F.	. 669
	Rate: 44 (100 per cent.)			Rate: 31.5 (100 per cent.)	
1935	M.	. 61		M.	. 41
		96	<i>Corrected</i>		76
	F.	. 35		F.	. 35
	Rate: 1.8 (4.1 per cent.)			Rate: 1.4 (4.5 per cent.)	

For comparison, the rate of syphilitic infections of less than one year's duration recorded at the treatment centres of England and Wales in 1935 was 1.47. The number of cases here included, other than primary and secondary cases, is very small and, when it is remembered that the Swedish figures represent 100 per cent. of cases and the figures for England and Wales probably represent only 85 per cent. of infections, it will be seen how unfavourably the rate of 1.47 compares with the 0.67 which is the rate for the whole of Sweden. In other words, the rate for Stockholm, the largest city and seaport in Sweden, including imported infections, is not significantly greater than the rate for the whole of England and Wales (probably about 1.7). I have chosen Liverpool as a British city and seaport roughly comparable to Stockholm. I have a personal knowledge of the work of the treatment centres in this Merseyside port and am confident that it is representative of the best efforts made under the present British V.D. campaign. In Liverpool in 1919 the number of cases of all forms of acquired and congenital syphilis, reporting for the first time at the treatment centres, was approximately 2,550; in 1935 the corresponding number was 945. The latter figure is 37 per cent. of the total for 1919. In Stockholm the figures are: 1,970 cases in 1919 and 101 cases in 1935, the latter being 5 per cent. of the total for 1919.

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The incidence of congenital syphilis in Sweden has been reduced to a greater degree than in this country, as illustrated by the following figures :

CONGENITAL SYPHILIS DEALT WITH FOR THE FIRST TIME

	Sweden.	England and Wales:	Ratio.
1931 . . .	31	2,439 ..	1 : 78
1935 . . .	19	2,031 ..	1 : 107
Population .	6,500,000	41,000,000 ..	1 : 6

The number of children in the "Welander" Homes, founded throughout Sweden early in this century for the treatment of children with congenital syphilis, is much depleted and on my visit to the "Welander" Home in Stockholm I was informed that the need for which it was originally founded was rapidly becoming non-existent.

In presenting the above statistics I have tried as far as possible to compare strictly comparable figures. This has not always been the case in other so-called comparisons in the past. As a result of my comparison I am unable to agree with the conclusion of the British Mission that "the degree of success in reducing the incidence of syphilis in the countries employing compulsory treatment and in those which rely on a voluntary system is broadly similar."

I am of the opinion that the existence of compulsory powers has contributed to the remarkable reduction in the incidence of syphilis in Sweden. I am equally convinced that the methods hitherto employed in Britain have failed to control the spread of V.D. and am of the opinion that the application in this country of a scheme modelled on the Swedish plan should be seriously considered. The Minister of Health should inaugurate a detailed survey of the V.D. problem in this country with a view to the trial of notification and compulsory measures. Notification must be by number unless and until the patient defaults and the measures must be applied, without discrimination, to both sexes and all sections of the community. To achieve success, a vigorous campaign to educate the public must be undertaken and such propaganda must display more drive and initiative than the educational efforts of the past. It is time that the man in the street was told the truth about V.D. in this country ; he cannot be expected to co-operate in solving the problem if he is ignorant of its existence. The medical profession also requires education, particularly in the epidemiological aspects of these diseases, as the success of any measures will depend on its full co-operation. The politician and the Press must also be brought into line and expert legal advice must be sought in drafting the necessary measures. Ecclesiastical support is essential. My contacts with representatives of the Church lead me to believe that their support would not be withheld and a precedent exists in the Scandinavian countries where the minister of religion formerly played an important part in searching out and bringing under treatment the sources of infection. The liberty of the subject has always rightly been subservient to the common good and thus compulsory powers would not infringe upon the principles of democracy. It would only require the inclusion of V.D. under the present law relating to con-

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tagious diseases, which has operated without hardship to the individual and with much benefit to the community.

" So we had to content ourselves with those who submitted to the treatment of their own free will. In this way the disease (syphilis) will never be eradicated "

Thus spoke Dr. Langhorn in 1788 in Denmark. Two and a half centuries later his fellow countrymen of Scandinavia have supplied positive proof of the wisdom of his words.

How long are we in this country to continue to provide the negative confirmation of this truth ? We are frequently warned nowadays by the Government that we must guard against complacency whilst fighting for our lives. In relation to V.D., I, in turn, ask the Government to avoid complacency and to insure that we fight to preserve healthy lives.

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IV

THE NEED FOR FURTHER POWERS TO DEAL WITH SOURCES OF INFECTION, CONTACTS AND DEFAULTERS

DISCUSSION

Dr. E. W. ASSINDER said that compulsory powers should be given to local authorities or to their Medical Officer of Health but he did not think that compulsory powers alone when dealing with individuals would be sufficient. The most effective remedy would be compulsory notification with powers to local authorities to ascertain the doctor's methods of diagnosis and treatment and tests of cure. Also, in the case of contacts the doctor should be required to state what methods of examination had been used. He suggested compulsory notification coupled with the right of the M.O.H. to have access to the record card of the patient and compulsory powers for the local authority to be used when necessary.

Dr. A. MURRAY STUART desired education of the medical profession. He was undecided whether notification would drive the disease underground or be beneficial. In his area the health visitor who had been used to follow up defaulters had proved much better than the Almoner because she was well known in the streets and was recognised as legitimately visiting and could do very useful work.

Dr. J. L. BURN described a scheme used in his area for two months in which out of 24 persons contacted, all promised to attend and actually 19 did so. These 19 included 5 cases of gonorrhœa in an infectious condition and 8 of primary or secondary syphilis. No difficulty was found in the case of husband and wife or of man and woman living together in approaching the other party. Quite good results were obtained. The Salford City Council had passed a resolution which called for compulsory examination and/or treatment of contacts. He hoped there would be more such resolutions.

Mrs. NEVILLE ROLFE thought that one of the factors in the success of the Scandinavian scheme was the additional two years' training of medical practitioners. Qualification to practise in Sweden included the equivalent of our post-graduate course in venereal diseases. One of the causes of the good results in the rural areas was the additional special training of every doctor before he took a rural appointment. Another big advantage was the compulsory inclusion of